Subchapter 18

Tumor Registry

37.8.1801 REPORTABLE TUMORS (1) The following tumors are designated as reportable:

(a) malignant neoplasm, with the exception of a basal or squamous carcinoma of the skin;

(b) skin cancer of the labia, vulva, penis or scrotum;

(c) benign tumor of the brain, including a:

(i) meningioma (cerebral meninges);

(ii) pinealoma (pineal gland); or

(iii) adenoma (pituitary gland);

(d) carcinoid tumor, whether malignant, benign or not otherwise specified (NOS).

(2) A benign tumor other than one of those listed in (1) may be reported to the department for inclusion in the tumor registry if prior approval has been obtained from the Department of Public Health and Human Services, Public Health and Safety Division, Montana Central Tumor Registry, 1400 Broadway, PO Box 202951, Helena, MT 59620-2951.

(3) A tumor which is otherwise reportable, but has been diagnosed and recorded using the words "apparently", "appears", "comparable with", "compatible with", "consistent with", "favors", "malignant appearing", "most likely", "presumed", "probable", "suspected", "suspicious", or "typical of" with reference to that tumor is considered reportable.

(4) In order for the department to maintain current reporting, hospitals and physicians shall submit to the department information on reportable tumors within six months from the first inpatient or outpatient date that the patient was seen with cancer; independent laboratories shall submit to the department information on reportable tumors within six months from the date the laboratory service associated with the tumor was rendered. (History: 50-15-706, MCA; IMP, 50-15-703, MCA; NEW, 1982 MAR p. 391, Eff. 2/26/82; AMD, 1985 MAR p. 1857, Eff. 11/30/85; AMD, 1988 MAR p. 726, Eff. 4/15/88; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03; AMD, 2009 MAR p. 87, Eff. 1/30/09.)

37.8.1802 REQUIRED RECORDS, INITIAL ADMISSION AND TREATMENT

(1) Whenever a hospital initially provides medical services to any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current physical address of patient;

(b) patient's physical address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) phone number;

(f) race, Hispanic origin if applicable, sex, and marital status;

(g) age at diagnosis, place of birth, and month, day, and year of birth;

(h) name, address, and phone number of friend or relative to act as contact, plus relationship of that contact to patient;

(i) date and place of initial diagnosis;

(j) primary site of tumor (paired organ);

(k) sequence of primary tumors if more than one;

(l) other primary tumors;

(m) method of confirming diagnosis;

(n) histology, including dates, place, histologic type and slide number;

(o) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of this staging;

(p) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined and site of distant metastases;

(q) procedures done to diagnose or stage tumors including dates, procedures, and results (such as physical exams, scopes, x-rays, scans, or lab tests);

(r) cumulative summary of all therapy directed at the subject tumor, including:

(i) date of therapy;

(ii) specific type of surgery or radiation therapy, if any, and details of chemical, hormonal, or other kinds of treatment; and

(iii) if no therapy given, reason for lack of therapy.

(s) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown;

(t) if recurrence of tumor, date, type, and distant sites of first recurrence;

(u) names of physicians primarily and secondarily responsible for follow up;

(v) date of each follow up;

(w) if patient has died, date of death, place, cause, and whether autopsy performed;

(x) primary payer at diagnosis;

(y) usual occupation and industry; and

(z) tobacco and alcohol use history. (History: 50-15-706, MCA; IMP, 50-15-703, MCA; NEW, 1982 MAR p. 391, Eff. 2/26/82; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03; AMD, 2009 MAR p. 87, Eff. 1/30/09.)

37.8.1803 REQUIRED RECORDS, FOLLOW UP (1) Whenever a patient for whom information has been provided to the tumor registry is admitted to the hospital providing the information on an inpatient or outpatient basis for further treatment related to the tumor for which original registration in the tumor registry was made, the hospital must keep on file the following information:

(a) patient's name, noting any change from previous records;

(b) any paired organ involvement, noting sequence;

(c) subsequent histology, including dates, place, histology type, slide number and procedure;

(d) date, type of procedure and findings of any surgery or other exploratory measure;

(e) date and type of any administration of radiation;

(f) date of any administration of hormones, chemotherapy, immunotherapy or any other kind of treatment;

(g) date of death and/or last follow up;

(h) if death has occurred, the place, cause and whether an autopsy was performed;

(i) if an autopsy was performed, its findings pertaining to cancer;

(j) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or has recurred, or status is unknown;

(k) if recurrence of tumor, date, type, and distant sites of first recurrence; and

(l) names of those physicians primarily and secondarily responsible for follow up treatment. (History: 50-15-706, MCA; IMP, 50-15-703, MCA; NEW, 1982 MAR p. 391, Eff. 2/26/82; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03; AMD, 2009 MAR p. 87, Eff 1/30/09.)

Rules 37.8.1804 through 378.1807 reserved

37.8.1808 REQUIRED RECORDS, INDEPENDENT CLINICAL LABORATORIES (1) Whenever a clinical laboratory which is not owned or operated by a hospital provides laboratory services for any patient relating to a tumor designated as reportable by ARM 37.8.1801, it must collect, record, and make available to the department the following information about that patient:

(a) name and current address of patient;

(b) patient's address at time of diagnosis;

(c) social security number;

(d) name of spouse, if any;

(e) race, sex, and marital status;

(f) age at diagnosis, month, day, and year of birth;

(g) date and place of initial diagnosis;

(h) primary site of tumor (paired organ);

(i) sequence of primary tumors, if more than one;

(j) method of confirming diagnosis;

(k) histology, including dates, place, histologic type, and slide number;

(l) summary staging, including whether in situ, localized, regional, distant or unstaged, with no information, or whether AJCC or TNM staging is utilized, and, if so, the findings of the staging;

(m) description of tumor and its spread, if any, including size in centimeters, number of positive nodes, number of nodes examined, and site of distant metastasis;

(n) status at time of latest recorded information, i.e., whether alive or dead, tumor in evidence, or recurring, or status unknown; and

(o) names of physicians primarily and secondarily responsible for follow up. (History: 50-15-706, MCA; IMP, 50-15-703, MCA; NEW, 1985 MAR p. 1857, Eff. 11/30/85; TRANS, from DHES, 1997 MAR p. 1460; AMD, 2003 MAR p. 2441, Eff. 10/31/03; AMD, 2009 MAR p. 87, Eff. 1/30/09.)